Division of TennCare

Health Care Innovation Initiative

Executive Summary

Spinal Fusion Episode

Corresponds with DBR and Configuration file V3.0

Updated: January 2, 2020

OVERVIEW OF A SPINAL FUSION EPISODE

The spinal fusion episode pertains to patients who receive a spinal fusion or a similar surgical procedure, such as total disc arthroplasty or laminoplasty. Throughout this document, references to spinal fusion procedures are intended to include these similar procedures. The trigger event is an inpatient admission or an outpatient visit with a spinal fusion procedure. All related care – such as anesthesia, imaging and testing, surgical and medical procedures, evaluation and management, and medications – is included in the episode. The quarterback, also called the principal accountable provider or PAP, is the clinician or group performing the spinal fusion procedure. The spinal fusion episode begins 30 days before the triggering procedure and ends 60 days after discharge.

CAPTURING SOURCES OF VALUE

Providers have multiple opportunities during a spinal fusion episode to improve the quality and cost of care. Important sources of value include appropriate use of evidence-based non-surgical therapies prior to the procedure, appropriate use of laboratory testing and imaging, suitable peri-operative management, and follow-up care. Providers can also choose the most appropriate procedure, reduce avoidable complications, and select the most appropriate site of discharge. There is also an opportunity for providers to use appropriate pain management strategies, including the tapering of any potentially addictive medications. Overall improvements in care such as these may reduce long-term complications, restore functionality, and optimize costs while also resolving the indications for the procedure.

To learn more about the episode's design, please reference the Detailed Business Requirements (DBR) and Configuration File on our website at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/searchable-episodes-table.html.

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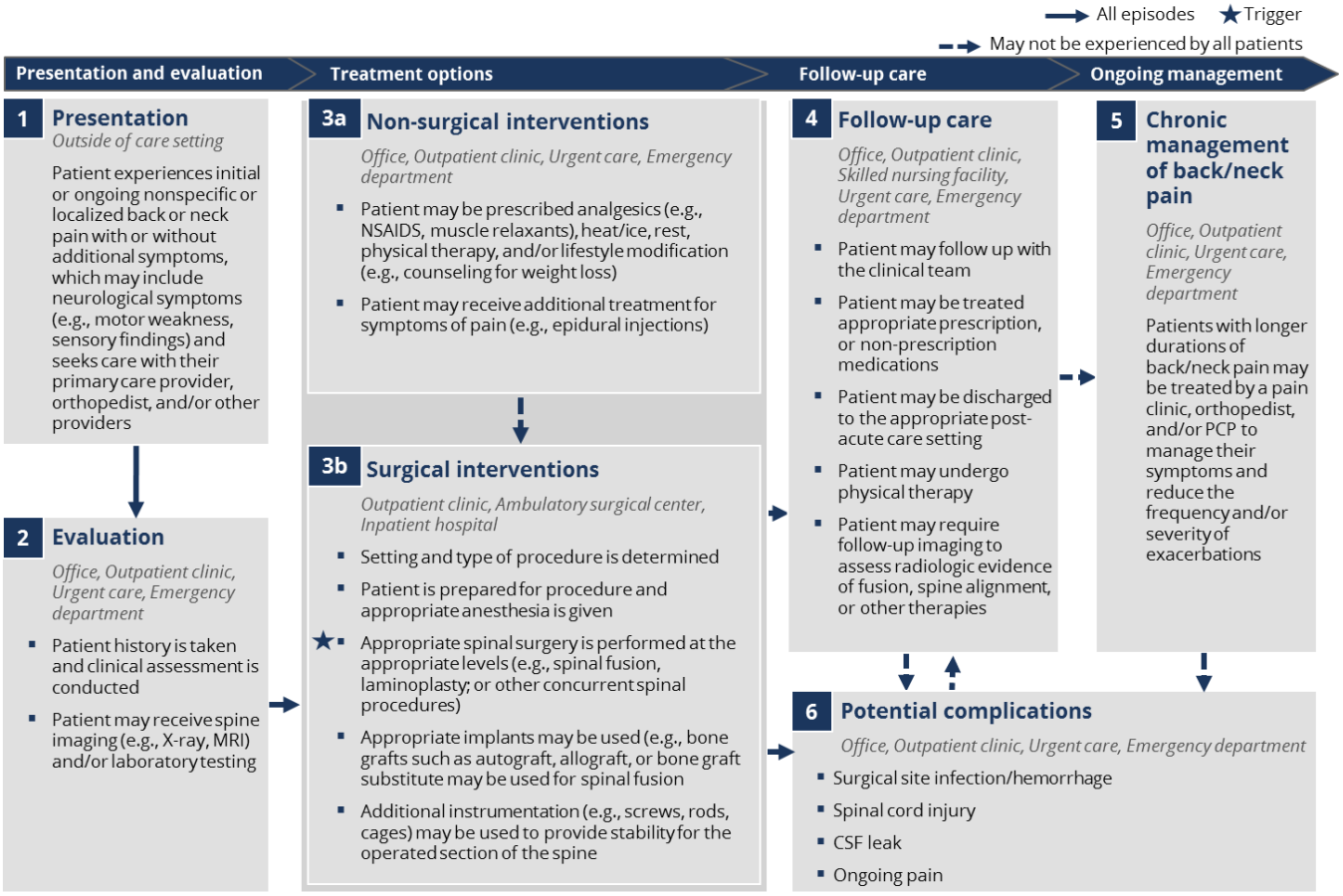
Illustrative Patient Journey



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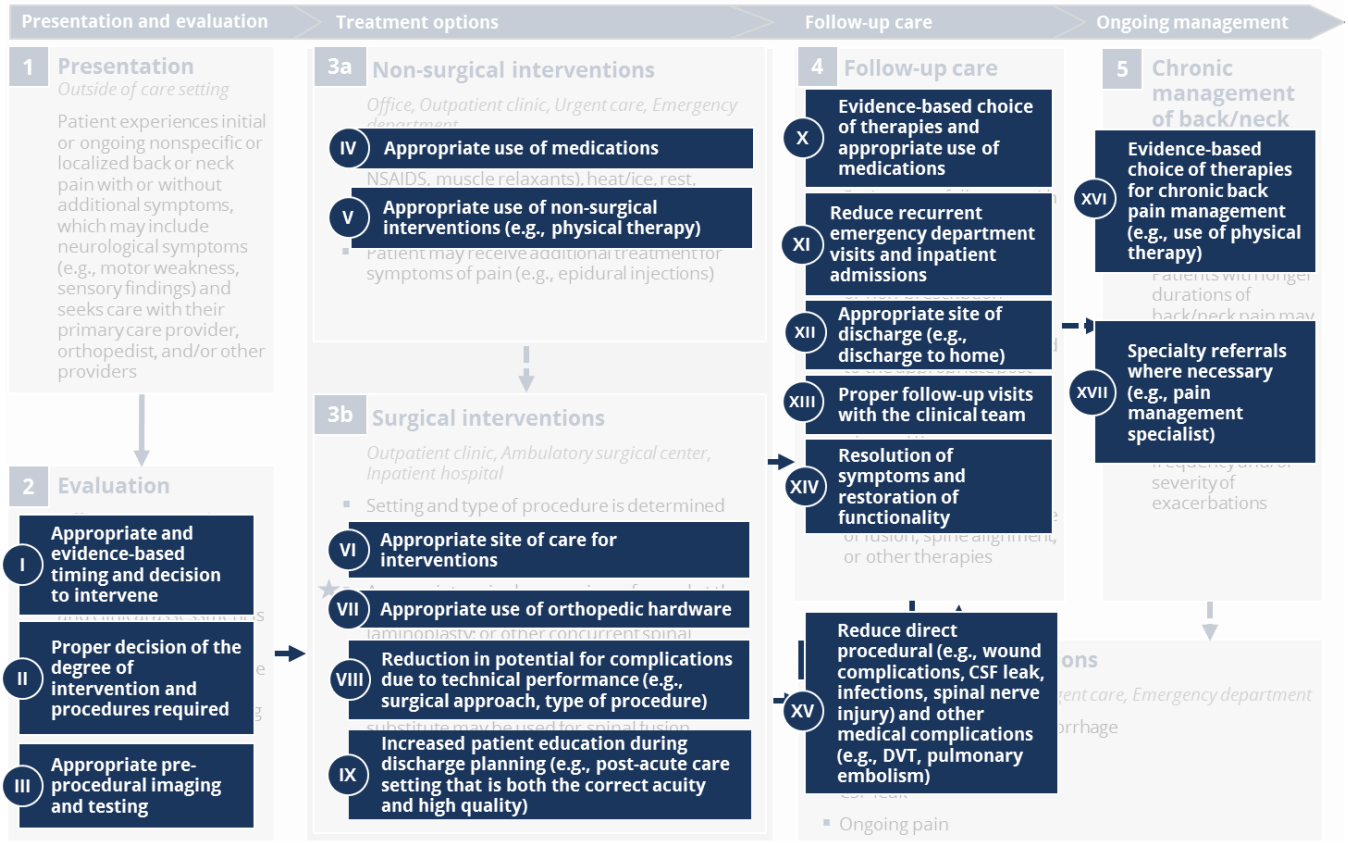
Potential Sources of Value



ASSIGNING ACCOUNTABILITY

The quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the spinal fusion episode, the quarterback is the clinician or group who performed the procedure. The contracting entity or tax identification number of the clinician or group performing the spinal fusion will be used to identify the quarterback.

MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

Updated: January 2, 2020

- Inclusion of only the cost of services and medications that are related to the spinal fusion procedure in calculation of episode spend.
- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The pre-trigger window of the spinal fusion procedure includes related evaluation and management visits, specific imaging and testing, and specific medications. During the trigger window, all services and specific medications are included. The post-trigger window 1 includes care for specific diagnoses, specific anesthesia, related evaluation and management visits, specific imaging and testing, specific medications, and specific surgical and medical procedures. The post-trigger window 2 includes specific surgical and medical procedures, specific anesthesia, and specific medications.

Some exclusions apply to any type of episode, i.e., are not specific to a spinal fusion episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Examples of exclusion criteria specific to the spinal fusion episode include patients who undergo combined anterior and posterior surgeries, spinal fusion more than six levels (with posterior instrumentation), spinal fusion more than seven levels (with anterior instrumentation), or staged procedures. These patients have significantly different clinical courses that the episode does not attempt to risk adjust. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of patient factors likely to lead to the risk adjustment of a spinal fusion episode include chronic pain, depression, anxiety,

obesity, substance use, or osteoporosis. Over time, a payer may adjust risk factors based on new data.

MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metric linked to gain sharing for the spinal fusion episode is:

- **Difference in Average MED[1]/day**: Average difference in morphine equivalent dose (MED)/day during the post-trigger opioid window and the pre-trigger opioid window (lower value indicative of better performance)

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Average MED/day during the pre-trigger opioid window**: Average morphine equivalence dose (MED)/day during the 31-60 days prior to the trigger window (lower value indicative of better performance)
- **Average MED/day during the post-trigger opioid window**: Average morphine equivalence dose (MED)/day during the 31-60 days after the trigger window (lower value indicative of better performance)
- **Related readmission**: Percentage of valid episodes with a related readmission during post-trigger window 1 (lower rate indicative of better performance)
- **Cervical procedure complication**: Percentage of valid cervical procedural episodes with a surgical complication during trigger window or post-trigger window 1 (lower rate indicative of better performance)

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1 MED: morphine equivalent dose

- **Lumbar procedure complication**: Percentage of valid lumbar procedural episodes with a surgical complication during trigger window or post-trigger window 1 (lower rate indicative of better performance)
- **Related follow-up care**: Percentage of valid episodes with related follow-up care during post-trigger window 1 (higher rate indicative of better performance)
- **Non-surgical management**: Percentage of valid episodes with non-surgical management (e.g., physical therapy) during the 365 days before the triggering procedure (higher rate indicative of better performance)
- **Post-discharge physical therapy**: Percentage of valid episodes with physical therapy during post-trigger window 1 or post-trigger window 2 (higher rate indicative of better performance)
- **Opioid and benzodiazepine prescriptions**: Percentage of valid episodes with both an opioid prescription and a benzodiazepine prescription filled during the episode trigger and post-trigger window (lower rate indicative of better performance)

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.